MASSPRO
Making an Impact.

COLORADO LEVEL I FORM
Pre-Admission and Resident Review (PASRR)

First Name: _____ Middle Initial: _____ Last Name: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Social Security #: _____-_____-_____ Date of Birth: _____/_____/_____

Gender: ☐ Male ☐ Female Race: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ Other: _____

Current Location: ☐ *Medical Facility ☐ *Psychiatric Facility ☐ *Nursing Facility ☐ Community ☐ Other: _____

*Provide Admission Date: _____ Receiving Nursing Facility: _____

Receiving Nursing Facility Address: _____ City: _____ State: _____ Zip: _____

Payment Method: ☐ Medicare ☐ Private Pay ☐ Medicaid ☐ Medicaid Pending ☐ Medicaid # _____

☐ Hospice ☐ PACE ☐ 30 Day PACE Respite

** Provide ULTC Scores if Medicaid or Medicaid Pending:
Bathing _____ Dressing _____ Toileting _____ Mobility _____ Transfer _____
Eating _____ Supervision Behaviors _____ Supervision Memory/Cognition _____

Section I: MENTAL ILLNESS

1. Does the individual have any of the following Major Mental Illnesses (MMI)?
- ☐ No
- ☐ Suspected: One or more of the following diagnoses is suspected (check all that apply)
- ☐ Yes: (check all that apply)
- ☐ Schizophrenia
- ☐ Schizoaffective Disorder
- ☐ Major Depression
- ☐ Psychotic/Delusional Disorder
- ☐ Bipolar Disorder (manic depression)
- ☐ Paranoid Disorder

2. Does the individual have any of the following mental disorders?
- ☐ No
- ☐ Suspected: One or more of the following diagnosis is suspected (check all that apply)
- ☐ Yes: (check all that apply)
- ☐ Personality Disorder
- ☐ Anxiety Disorder
- ☐ Panic Disorder
- ☐ Depression (mild or situational) (provide GDS Score: _____)

3. Does the individual have a diagnosis of a mental disorder that is not listed in #1 or #2? (do not list dementia here)
- ☐ No
- ☐ Yes (if yes, enter the diagnosis(es) below):
- ☐ Diagnosis 1: _____
- ☐ Diagnosis 2: _____

Section II: SYMPTOMS

4. **Interpersonal—Currently or within the past 6 months, has the individual exhibited interpersonal symptoms or behaviors [not due to a medical condition]?:** ☐ No ☐ Yes
- ☐ Serious difficulty interacting with others
- ☐ Altercations, evictions, or unstable employment
- ☐ Frequently isolated or avoided others or exhibited signs suggesting severe anxiety or fear of strangers

5. **Concentration/Task related symptoms—Currently or within the past 6 months, has the individual exhibited any of the following symptoms or behaviors [not due to a medical condition]?** ☐ No ☐ Yes
- ☐ Serious difficulty completing tasks that she/he should be capable of completing
- ☐ Required assistance with tasks for which she/he should be capable
- ☐ Substantial errors with tasks in which she/he completes

Adaptation to change—Currently or within the past 6 months, has the individual exhibited any symptoms in #6, 7 or 8 related to adapting to change? ☐ No (proceed to Section III) ☐ Yes (complete 6-8)

6.
- ☐ Self injurious or self mutilation
- ☐ Suicidal talk
- ☐ History of suicide attempt or gestures
- ☐ Physical violence
- ☐ Physical threats (with potential for harm)

7.
- ☐ Severe appetite disturbance
- ☐ Hallucinations or delusions
- ☐ Serious loss of interest in things
- ☐ Excessive tearfulness
- ☐ Excessive irritability
- ☐ Physical threats (no potential for harm)

GDS Score: _____ (if any areas in #7 are marked)

8. ☐ Other major mental health symptoms (this may include recent symptoms) that have emerged or worsened as a result of recent life changes as well as ongoing symptoms. Describe symptoms:

_____
_____
_____

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Section III: HISTORY OF PSYCHIATRIC TREATMENT

9. Currently or within the past 2 years, has the individual received any of the following mental health services?
- ☐ No
- ☐ Yes (the individual has received the following service[s]):
  - ☐ Inpatient psychiatric hospitalization (if yes, provide date: _____)
  - ☐ Partial hospitalization/ day treatment (if yes, provide date: _____)
  - ☐ Residential treatment (if yes, provide date: _____)
  - ☐ Other: _____(if yes, provide date: _____)

10. Currently or within the past 2 years, has the individual experienced significant life disruption because of mental health symptoms? ☐ No ☐ Yes (check all that apply):
- ☐ Legal intervention due to mental health symptoms (date: _____)
- ☐ Housing change because of mental illness (date: _____)
- ☐ Suicide attempt or ideation (date[s]: _____)
- ☐ Other: _____ (date: _____)

11. Has the individual had a recent psychiatric/behavioral evaluation? ☐ No ☐ Yes (date: _____)

Section IV: DEMENTIA

12. **Does the individual have a diagnosis of dementia or Alzheimer's disease?** ☐ No (proceed to 15) ☐ Yes

13. If yes to #12, is corroborative testing or other information available to verify the presence or progression of the dementia?
☐ No ☐ Yes (check all that apply)
☐ Dementia work up ☐ Comprehensive Mental Status Exam
☐ Other (specify): _____

14. If yes to12, list currently prescribed antidepressant or antipsychotic medications listed on the Beer's List.

Medication	Dosage MG/Day	Refer to Beer's List
		Does dosage exceed Beer's List? ☐No ☐Yes
		Does dosage exceed Beer's List? ☐No ☐Yes
		Does dosage exceed Beer's List? ☐No ☐Yes

Section V: PSYCHOTROPIC MEDICATIONS

15. Has the individual been prescribed psychoactive (mental health) medications now or within the past 6 months other than those listed in question 14? ☐ No ☐ Yes (list below) [use separate sheet if necessary] * *Do not list medications if used for a medical diagnosis.*

Medication	Dosage MG/Day	Diagnosis	Started	Ended

Section VI: MENTAL RETARDATION & DEVELOPMENTAL DISABILITIES

16. Does the individual have a diagnosis of mental retardation (MR) or developmental disability (DD)? ☐ No ☐ Yes

17. Does the individual have any history of MR or DD? ☐ No ☐ Yes

18. Is there presenting evidence of a cognitive or behavioral impairment prior to age 22 or suspicion of MR condition that occurred prior to age 18? ☐ No ☐ Yes

19. Has the individual ever received services from an agency that serves people affected by MR/DD? ☐ No
☐ Yes—agency: _____

Section VII: EXEMPTION AND CATEGORICAL DECISIONS (MASSPRO MUST APPROVE USE OF CATEGORIES AND EXEMPTION PRIOR TO ADMISSION)

20. Does the admission meet criteria for Hospital Exemption?
☐ No
☐ Yes (meets all the following **and** has a known or suspected MMI or MR/DD):
- Admission to NF directly from hospital after receiving acute medical care, and
- Need for NF is required for the condition treated in the hospital (specify condition: _____,) and
- The attending physician has certified prior to NF admission the individual will require less than 30 calendar days of NF services and the individual's symptoms or behaviors are stable.

Physician Name: _____
Physician Phone: _____
Physician License #: _____

22. Does the admission meet the criteria for Terminal Illness?
☐ No
☐ Yes (Has a known or suspected MMI or MR/DD and MD has certified in writing that the patient has 6 months or less to live. The physician signed certification must be submitted to Masspro via facsimile within 6 business hours of submission of this form)

23. Does the admission meet the criteria for Severity of Illness?
☐ No
☐ Yes (Has a known or suspected MMI or MR/DD and is ventilator dependent or comatose unresponsive)

24. Does the admission meet criteria for 60 day Convalescence?
☐ No
☐ Yes (meets all the following and has a known or suspected MMI or MR/DD): ☐ Admission to NF directly from hospital after receiving acute medical care; and ☐ Need for NF is required for the condition treated in the hospital, and ☐ The attending physician has certified prior to NF admission the individual will require less than 60 calendar days of NF services.

21. Additional Comments: _____

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Section VIII: OUTCOME	
25. Are any of the following numbers marked yes or, if applicable, suspected 1, 3, 6, 7, 8, 9, 10, 14, 15, 16, 17, 18, or 19?	☐ No ☐ Yes
26. Check yes if #2 is marked yes or suspected and any areas in #4-8 are marked	☐ No ☐ Yes
27. Check yes if #4 or 5 or (any areas in) #7 are marked affirmatively and #12 is no	☐ No ☐ Yes

28. Are any of the #25-27 marked yes?
☐ No (if No, NO further screening is required. Proceed to Section IX)
☐ Yes (Screening information must be submitted to Masspro via fax at 1-855-222-3114 for a determination of whether further screening is required).

Provide a copy of this form to the individual and, if applicable, guardian.

Does the individual have a legal guardian? ☐ ***No legal guardian*** ☐ ***Yes, legal guardian information is below:***

Guardian Last Name: _____ First Name: _____

Street: _____ City: _____ State: _____ Zip: _____

Section IX: SOURCE SIGNATURE		
Print Name:	Signature:	Date: / /
Agency/Facility:	Phone:	Fax:

Section X: MASSPRO OUTCOME: MASSPRO USE ONLY

Date: _____

Non-Cert ☐

Level I Approved: PASRR Authorization #: _____

☐ No MMI/DD

☐ Follow-up next qtr. _____ ☐ PACE Respite _____ ☐ 30 Day Exemption _____

☐ Hospice _____ ☐ Convalescent Care _____ ☐ Terminal _____

☐ Severity of Illness _____

☐ Provisional-Out of state Adm. _____ ☐ Provisional-Emergency Adm. _____

Level II Referred: ☐ MI ☐ MR/DD ☐ Dual

Comments: _____